

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

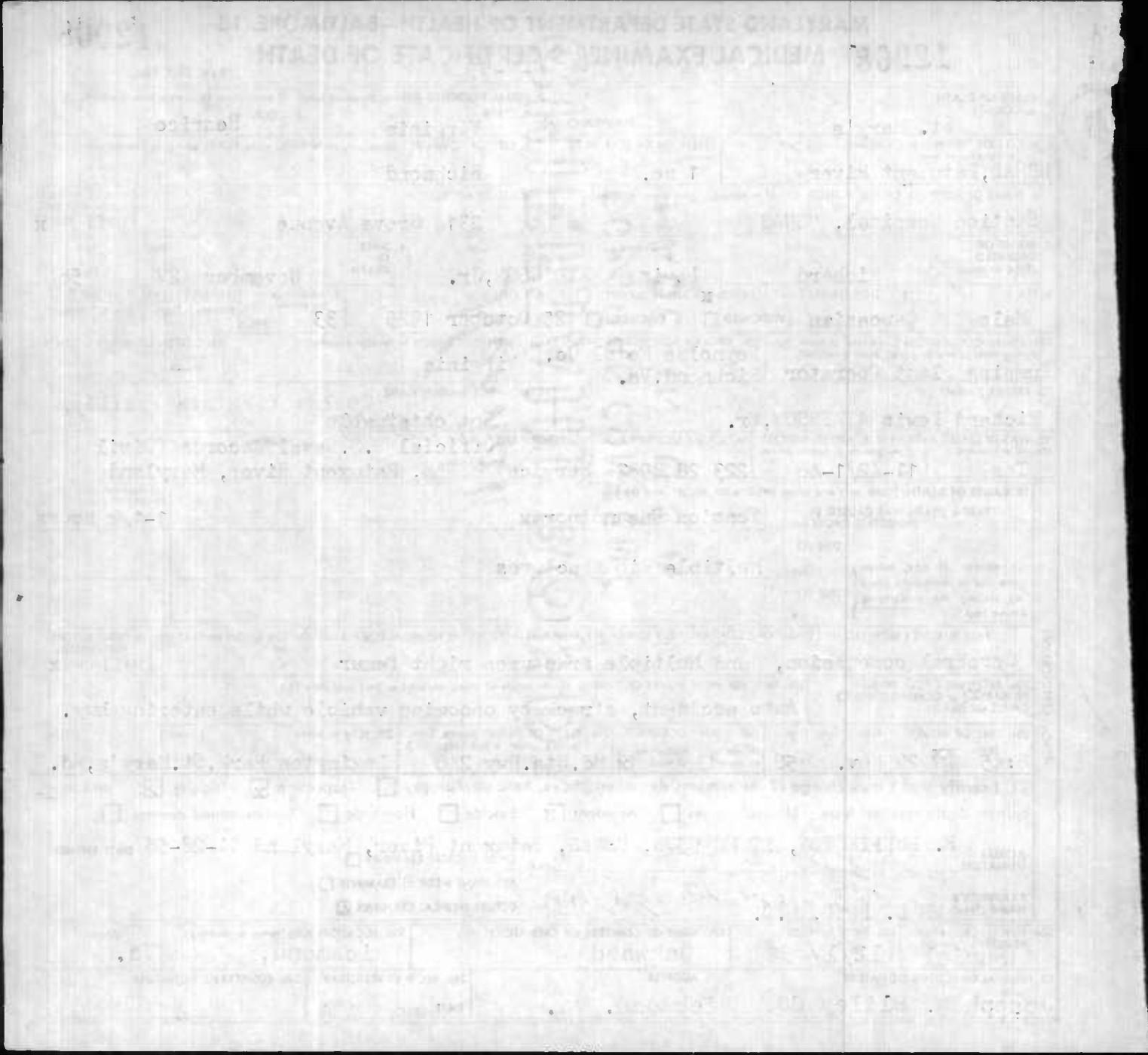
12908 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 File #243 6-2-59 et

12908

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY <b>Henrico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>USNAS, Patuxent River</b>		c. LENGTH OF STAY IN lb <b>1 mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Richmond</b>		d. STREET ADDRESS <b>2314 Grove Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Station Hospital, USNAS</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Richard</b>	Middle <b>Lewis</b>	Last <b>ATKINSON, Jr.</b>	4. DATE OF DEATH <b>November 27 1958</b>	Month <b>November</b>	Day <b>27</b>	Year <b>1958</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>25 October 1925</b>	9. AGE (In years last birthday) <b>33 yrs</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pumping Plant Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Reynolds Metal Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Lewis ATKINSON, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Thelma Virginia Phillips</b>		Not obtainable			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>11-42-1-46</b>		17. INFORMANT <b>Official U.S. Naval Records (Civil Service) USNAS, Patuxent River, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tension Pneumothorax</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Multiple Rib Fractures</b> DUE TO cause last. (c)	
						INTERVAL BETWEEN ONSET AND DEATH <b>1-1/2 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Cerebral concussion, and Multiple fractures right femur</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto accident, struck by oncoming vehicle while entering hwy.</b>					
20c. TIME OF INJURY Hour <b>8:45</b>		Month, Day, Year <b>p.m. 27 Nov. 1958</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> <b>Md. Sta. Hwy 246</b>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Lexington Park, St. Mary's, Md.</b>	
20f. (City or town) <b>Lexington Park, St. Mary's, Md.</b>		(County) <b>St. Mary's</b>		(State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE: <b>R. BUFFINGTON, LT MC USNR, USNAS, Patuxent River, Maryland 11-28-58 DATE SIGNED</b>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/1/ 58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Oakwood</b>		22d. LOCATION (City, town, or county) <b>Richmond,</b> (State) <b>Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph W. Bliley CO. Richmond. Va.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 2 1958</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kranz</b>	



FOR STATE  
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME  
5M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12909 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12909

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Great Mills</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Great Mills</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>James</b>	Middle <b>Louis</b>	Last <b>Barber</b>	4. DATE OF DEATH <b>11 / 18 / 58</b>	Month Doy Year
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>? 1914</b>	9. AGE (In years lost birthday) <b>44</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Parren Barber</b>		14. MOTHER'S MAIDEN NAME <b>Mandy Barber</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-32-7945</b>		17. INFORMANT <b>Jos. M. Barber - Great Mills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>812 X</b>		Fractured Skull		INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hit by auto -</b>			
20c. TIME OF INJURY <b>7:30 p.m. 11-18-58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>STATE ROUTE #5</b>	
20f. (City or town) <b>Great Mills</b>		(County) <b>St. Marys</b>		(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Wm. D. Boyd</b>		DATE SIGNED <b>11/19/58</b>			
EXAMINER'S NAME (Type) <b>Wm. D. Boyd MD</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/22/58</b>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Holy Face Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Great Mills</b>		(State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.H. Robinson - Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knapp</b>	

STATE OF CALIFORNIA

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF CALIFORNIA

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG236 12-15-58 et

12910

12910

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtown</i>		c. LENGTH OF STAY IN lb <i>1 1/2 days</i>		b. COUNTY <i>St. Mary's</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtown</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. Mary's Hospital</i>				d. STREET ADDRESS <i>Leonardtown</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>James Thomas Bowles</i>		First <i>James</i>		Middle <i>Thomas</i>		Last <i>Bowles</i>	
4. DATE OF DEATH <i>11 - 2 1958</i>		Month <i>11</i>		Day <i>2</i>		Year <i>1958</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		B. DATE OF BIRTH <i>10-31-58</i>	
8. WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) yrs. <i>—</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>—</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>			
11. BIRTHPLACE (State or foreign country) <i>Leonardtown Md</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			
13. FATHER'S NAME <i>James H. Bowles</i>				14. MOTHER'S MAIDEN NAME <i>Margaret b Vallandingham</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>				16. SOCIAL SECURITY NO. <i>—</i>			
17. INFORMANT <i>Margaret b. Bowles Leonardtown Md</i>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>762.5</i> DUE TO <i>Respiratory arrest</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Innate</i> (c)							
INTERVAL BETWEEN ONSET AND DEATH <i>10 min.</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> <i>2 days</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m.      p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10/31/58</i> , 19, to <i>11/2/58</i> , 19, that I last saw the deceased alive on <i>11/1/58</i> , 19, and that death occurred at <i>3:15 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Joseph E. Gill</i> M.D. ADDRESS (Street, city or town, state) <i>Leonardtown, Md</i> DATE SIGNED <i>11/2/58</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-3-58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Aloysius</i>		22d. LOCATION (City, town, or county) (State) <i>Leonardtown Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W.C. Mattiuzzley Leonardtown, Md.</i>				ADDRESS <i>Leonardtown, Md.</i>		24a. REC'D BY REGISTRAR DATE NOV 5 '58	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF ILLINOIS  
DEPARTMENT OF REVENUE  
CERTIFICATE OF DEATH

01

RECEIVED  
MAY 10 1968

H. J. HARRIS

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

The bottom copy may be retained by the hospital or attending physician.

VS AISC 1-55 10M

15  
**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**  
Items 8,9,10,13,14/FilmG236 12-3-58 et

12911

# **12911 CERTIFICATE OF DEATH**

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY St. Mary's MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rural Mechanicsville		STATE Maryland COUNTY St. Mary's CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Mechanicsville STREET ADDRESS	
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
Arthur Bush		Nov. 24, 1958	
S. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 26, 1888
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John A. Bush		14. MOTHER'S MAIDEN NAME Julia Ann (Last name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unk.) No		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> 422.1 IMMEDIATE CAUSE (A) <i>Atherosclerotic cardiovascular disease</i>		<b>18. MEDICAL CERTIFICATION</b> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>		INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
<b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.</b>			
SIGNATURE <i>Roy Engster</i>		ADDRESS (Street, city, town, state) <i>Rural Mechanicsville, Md.</i> DATE SIGNED <i>11/25/58</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 11/28/58	NAME OF CEMETERY OR CREMATORIAL JOHN WESTLEY	LOCATION (City, town, or county) (State) Chaptico, Md.
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. Clarke Mattingley Leonardtown, Md.	
DATE NOV 26 '58	---		

DEPARTMENT OF STATE - CALIFORNIA

CERTIFICATE OF DEATH

1900

REGISTRATION NO. 1234567890

DEATH  
CERTIFICATE

REGISTRATION

DEATH

REGISTRATION

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REGISTRATION

REGISTRATION NO. 1234567890

REGISTRATION NO. 1234567890

DEATH

REGISTRATION

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12912 CERTIFICATE OF DEATH

12912

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN lb				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>AMELIA</b>	Middle ----- <b>CHAP</b>	4. DATE OF DEATH Month <b>November 23</b> Year <b>1958</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 16, 1907</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>domestic</b>	11. BIRTHPLACE (State or foreign country) <b>Illinois</b>			
13. FATHER'S NAME <b>Joseph Bohatka</b>		14. MOTHER'S MAIDEN NAME <b>Sophe Smeya</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. -----	17. INFORMANT <b>Gloria J. Shinn -66 Salamaue Ct. Md.</b>			
Address <b>Lexington Park, Md.</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO <b>170X</b>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Carcinomatosis</b> DUE TO (c) <b>Carcinoma of left breast.</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) -----	(County) -----	(State) -----
21. I certify that I attended the deceased from <b>9/22</b> , 19 <b>58</b> , to <b>11/23</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/23/58</b> , 19 <b>58</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.						
				ADDRESS (Street, city or town, state) <b>Hollywood Maryland</b>		
				DATE SIGNED <b>11/23/58</b>		
ACTUAL SIGNATURE <b>A. Samadi</b>		PHYSICIAN'S NAME (Type) <b>ABDUSSAMED SAMADI M.D.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>11/23/58</b>		22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) <b>Bellaire, Ohio</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>DEC 1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by it—hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12913

## CERTIFICATE OF DEATH

12913

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridge</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridge</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <b>William</b>	Middle <b>Warren</b>	Last <b>Clarke</b>	4. DATE OF DEATH Month <b>Nov.</b>	Day <b>30,</b>	Year <b>1958</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 21, 1868</b>	9. AGE (In years last birthday) <b>90</b>	IF UNDER 1 YEAR Months <b>90</b>	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tidewater fisheries</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State of Md.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Worthington Clarke</b>		14. MOTHER'S MAIDEN NAME <b>Ann Milburn</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>No.</b>		17. INFORMANT <b>Virginia A. Clarke</b>		Address <b>Ridgen Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Armenia</b> 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic nephritis</b> (c) <b>Generalized arteriosclerosis</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov.</b> , 19 <b>58</b> , to <b>Nov. 30, 1958</b> , that I last saw the deceased alive on <b>Nov. 29, 1958</b> , and that death occurred at <b>10A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Great Mills, Maryland</b>							
ACTUAL SIGNATURE <b>P. J. Bean M.D.</b> DATE SIGNED <b>Dec 11 58</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/4/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Michael's</b>		22d. LOCATION (City, town, or county) (State) <b>Ridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Maryland</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>DEC 3 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Enter this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be deleted for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5 10W

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

12914

**12914 CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	St. Mary's Rural Hollywood	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural Hollywood
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	(If rural give location)
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b>	
(First) James Thomas		(Middle)	(Last) Greenwell
S. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH May, 7, 1892
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 66 yrs.
13. FATHER'S NAME James T. Greenwell		14. MOTHER'S MAIDEN NAME Laura Mae Redman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 220-16-4665	
17. INFORMANT & ADDRESS Phoebe E. Greenwell Hollywood, Md.		18. MEDICAL CERTIFICATION <i>Myocarditis Cardiac failure</i> <i>Cardiac disease</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>422.2 IMMEDIATE CAUSE</b> (A) _____ ANTECEDENT CAUSE(S) DUE TO _____ DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO _____ (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <i>None</i>		19b. MAJOR FINDINGS OF OPERATION <i>None</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i>None</i>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i>None</i>	
21c. WHERE DID INJURY OCCUR? (City or town) <i>None</i>		(County) <i>None</i> (State) <i>None</i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>None</i>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <i>None</i>			
22. I hereby certify that I attended the deceased from <i>Oct 25</i> , 19 <i>58</i> , to <i>Nov 25</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Nov 25</i> , 19 <i>58</i> , and that death occurred at <i>5:30 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Charles Greenwell</i>		ADDRESS (Street, city, town, state) <i>Leonardtown, Md.</i> DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11/29/1958	NAME OF CEMETERY OR CREMATORIAL M.D. Saint John's
24. REC'D BY REGISTRAR DATE DEC 2 '58		REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	LOCATION (City, town, or county) (State) Hollywood, Maryland
25. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Md.	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

## Item 11 Film 236 12-11-58 ams

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12915

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maddox		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS X Rural Maddox.	
e. IS RESIDENCE ON FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frederick Cleveland		First Middle	Lost
4. DATE OF DEATH Nov.		Month	Day Year 30, 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 5, 1958
10a. USUAL OCCUPATION (Give kind of work done during most recent full-time life, even if retired) 888888		10b. KIND OF BUSINESS OR INDUSTRY #####	11. BIRTHPLACE (State or foreign country) Maryland Alabama
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Joseph Higgs		14. MOTHER'S MAIDEN NAME Rae Higgs Boswell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Joseph Higgs
		Address Maddox, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 344x DUE TO Hypdrocephalus		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>David L. Moseman</i> M.D. <i>Mechanicsville Md.</i> DATE SIGNED <i>Arthur S. Frank</i>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/1/58	22c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart
22d. LOCATION (City, town, or county) Bushwood, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE DEC 3 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Frank



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12916

## CERTIFICATE OF DEATH

12916

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>St. Mary's</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>St. Mary's</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtown</i>		c. LENGTH OF STAY IN 1b <i>7 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mechanicsville</i>		d. STREET ADDRESS <i>#266A Route 5</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>78 St. Mary's</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Hilda Louise Meredith</i>		First	Middle	Last	4. DATE OF DEATH <i>Nov 29 1958</i>	Month	Day	Year	
5. SEX <i>female</i>		6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>11-29-58</i>	9. AGE (In years last birthday) yrs. <i>38</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>38</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Raymond Meredith</i>		14. MOTHER'S MAIDEN NAME <i>Gerdie Thomas</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Hospital Records</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>760.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>INDETERMINED CAUSE - POSSIBLE</i> <i>INTRACRANIAL HEMORRHAGE</i> (c)						INTERVAL BETWEEN ONSET AND DEATH <i>10 MIN</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>BREATH PRESENTATION; ASPHYXIA; RESPIRATIONS NOT ESTABLISHED</i>						19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>6:00PM 11/29, 1958, to 6:10 11/29, 1958, that I last saw the deceased alive on 11/29, 1958, and that death occurred at 6:10 P.M., from the causes and on the date stated above.</i>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Mechanicsville, Maryland</i>		20f. (City or town) (County) (State) <i>(County) (State)</i>			
21. I certify that I attended the deceased from 6:00PM 11/29, 1958, to 6:10 11/29, 1958, that I last saw the deceased alive on 11/29, 1958, and that death occurred at 6:10 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. Roy Guyther</i>						ADDRESS (Street, city or town, state) <i>M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/30/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Aloysius</i>		22d. LOCATION (City, town, or county) (State) <i>Leonardtown, Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Clarke Mattingley Leonardtown, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>DEC 8 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12917

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. George Island		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		X d. STREET ADDRESS St. George Island	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William Harry Robrecht		First Middle Lost	4. DATE OF DEATH Month Day Year November 21, 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 18, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Robrecht	
14. MOTHER'S MAIDEN NAME Anna Twilley		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Lelia M. Robrecht St. George Island, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Urinary</i> 609x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Ascending urinary tract infection</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis and chronic arthritis.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov. 19, 1958</i> , to <i>Nov. 21, 1958</i> , that I last saw the deceased alive on <i>Nov. 19, 1958</i> , and that death occurred at <i>12:30 P.M.</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>P. J. Bean</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>Nov. 21/58</i>	
PHYSICIAN'S NAME (Type) P. J. Bean M. D.		Great Mills, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/24/58	22c. NAME OF CEMETERY OR CREMATORIUM St. Francis	22d. LOCATION (City, town, or county) (State) St. George Island, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE NOV 25 '58	
		24b. REGISTRAR'S SIGNATURE <i>Orion L. Turner</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12918

## 12918 CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	St. Mary's St. George Island	MARYLAND LENGTH OF STAY (In this place) Life	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN St. George Island (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS		
<b>3. NAME OF DECEASED (Type or Print)</b>		<b>4. DATE (Month) (Day) (Year)</b>	
Gabriel Edward Thomas		Nov. 28, 1958	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH March 27, 1876
9. AGE last birthday 82 yrs.	10. KIND OF BUSINESS OR INDUSTRY Postmaster	11. BIRTHPLACE (State or foreign country) St. George Island	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George W. Thomas	14. MOTHER'S MAIDEN NAME Margaret		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. None	17. INFORMANT & ADDRESS Myrtle P. Thomas St. George Island, Maryland	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
420.1 IMMEDIATE CAUSE (A) <i>Coronary occlusion</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary sclerosis</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Genuvalgic arteria sclerosis</i>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Nov. 23, 1958</i> , to <i>Nov. 26, 1958</i> , that I last saw the deceased alive on <i>Nov. 27, 1958</i> , and that death occurred at <i>11:30 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>D. P. Henr</i> M.D. ADDRESS (Street, city, town, state) <i>Grant Bull Rd</i> DATE SIGNED <i>Nov 29/58</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 12/1/58	NAME OF CEMETERY OR CREMATORIUM Cedar Hill	LOCATION (City, town, or county) 4000 Suitland Road Washington, D.C.
24. REC'D BY REGISTRAR DATE DEC. 3 '58	REGISTRAR'S SIGNATURE <i>John J. L. H.</i>		
25. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.			

HOABO TO KADOMBO

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. After this bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

Item 11 Film G236 12-3-58 et

12919

**CERTIFICATE OF DEATH**

Item 1 Film G236 12-4-58 et

12919

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	St. Mary's Leonardtown	MARYLAND LENGTH OF STAY (in this place) 14 days	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Park Hall STREET ADDRESS (If rural give location)
<b>3. NAME OF DECEASED</b> (First) James      (Middle) Robert      (Last) Vincent		<b>4. DATE OF DEATH</b> Nov. 23, 1958	
S. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH March 1, 1886
9. AGE last birthday 72 yrs.	10. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. 216-10-1978	17. INFORMANT & ADDRESS Bernice V. Utile Park Hall, Md.	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
IMMEDIATE CAUSE (A) Bronchopneumonia	INTERVAL BETWEEN ONSET AND DEATH 2 weeks		
ANTECEDENT CAUSE(S) DUE TO Chronic myocarditis	3 years		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) (C) Coronary sclerosis	10 years		
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
<b>22. I hereby certify that I attended the deceased from Nov. 23, 1958, to Nov. 23, 1958, that I last saw the deceased alive on Nov. 23, 1958, and that death occurred at 5 P.M., from the causes and on the date stated above.</b>			
SIGNATURE <i>John</i>		ADDRESS (Street, city, town, state) <i>Great Mills Md</i>	DATE SIGNED <i>Nov 24/58</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 11/26/58	NAME OF CEMETERY OR CREMATORIAL Ebenezer	LOCATION (City, town, or county) (State) Great Mills, Md.
24. REC'D BY REGISTRAR NOV 26 '58	REGISTRAR'S SIGNATURE <i>J. Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. Clarke Mattingley Leonardtown, Md.	
DATE			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained for you.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.



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STATE OF CALIFORNIA  
DEPARTMENT OF MOTOR VEHICLES  
MEDICAL EXAMINERS CERTIFICATE OF DEATH

NAME

AGE

SEX

DEATH OCCURRED ON DATE

CAUSE OF DEATH

EXAMINER'S SIGNATURE

EXAMINER'S SIGNATURE